

# TOPICAL AGENT PRIOR AUTHORIZATION REQUEST FORM



*OptumRx*  
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Today's Date

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**Note:** This form must be completed by the prescribing provider.

**\*\*All sections must be completed or the request will be returned\*\***

Patient's Medicaid # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name
Prescriber's IN License # <input type="text"/>	Specialty
Prescriber's NPI # <input type="text"/>	Prescriber's Signature
Return Fax # <input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone # <input type="text"/> - <input type="text"/> - <input type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable):

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

Requested Medication	Strength	Quantity	Dosage Regimen	Diagnosis

**PA Requirements:**

1. What is the prescriber's specialty? \_\_\_\_\_
2. Have any other providers been consulted in the prescribing of the requested agent?  Yes  No  
 If yes, please provide the other provider's specialty: \_\_\_\_\_
3. Has the member tried and failed any other medication(s) for the requested diagnosis?  Yes  No  
 If yes, please provide drug/dose/date(s) of use:

Drug(s) and Dose	Dates of Use

4. Provide medical justification for use at requested dose and duration:

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**Additional Drug-Specific Questions:** (Not required if not applicable)

**Topical NSAIDs:**

1. Are oral medications unsuitable for member use?  Yes  No  
If yes, faxed prescriber documentation (e.g., medical chart record) is required to be attached.

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